Integration and the Child

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The integration of behavioral and physical health has become a national priority as increasing evidence points to the connection between adverse experiences, behavioral health and a wide range of physical health problems across the life span. This mounting research is critical to understanding and providing the best possible treatments to those affected by mental health issues, but it also speaks to policy decisions related to health care spending. While much of the planning and efforts toward integration have involved services to adults, it is critical to understand and include the needs of children. This article will address some key differences in planning for integration between these populations, discuss the special circumstances faced when dealing with children, and highlight models and strategies that have been undertaken and show promise.

Changing the Paradigm

"Integrated health care is the systematic coordination of physical and behavioral health care. The idea is that physical and behavioral health problems occur at the same time. Integrating services to treat both will yield the best results and be the most acceptable and effective approach for those being served." - The Hogg Foundation

for Mental Health

The move to understand and integrate physical and mental health services has reached a critical phase in planning and organization. To date, much of the effort has involved the primary care office as the point of entry. In traditional models, this makes sense for several reasons: most adult patients will use the primary care physician when reporting difficulties with and seeking help for mental health challenges, and there is also a greater likelihood that primary care services will be covered by insurance. The strategy, therefore, is to bring mental health services under the purview of the primary care physician and manage physical and mental health care under this more traditional medical model.

Where an adult may be able to access, advocate and play an active role in securing coordinated care, a child depends on multiple "stakeholders". Parents, caregivers, educators and other health professionals, all with various degrees of expertise and opinion on the child's well-being, are expected to play a role in assisting the child. Making matters more complex is the notion that behavioral difficulties in children are noticed in various child-serving settings including their primary care physicians' offices but also their schools and recreation centers, which are not fully encompassed in the "integration" formula. In the last decade, there have been great strides forward in Philadelphia as the mental health community has collaborated with the city's school district to incorporate

behavioral health services in the schools. When it is done well, the strategy is not to simply deliver services within the school building but to become integrated within the school's culture. This model of integration applied in schools may also be applied to other settings such as primary care. Only when these stakeholders are together at the table with the family will a lasting and transformative dialogue occur.

Opportunities

The United States spends more per person on health care than any other nation in the world, and has, arguably, some of the greatest health care available in the world. We have passed the Affordable Care Act, and health care is now available to an even greater percentage of our citizens. Despite these efforts, the United States still evidences poor outcomes in areas such as overall life expectancy and rates of obesity, diabetes and heart disease, among others. Of course, these results worsen along some predictable variables such as socioeconomic status, access to health care and poor education achievement. The end result is that as a nation we are spending more but achieving less with our current system. We are chasing the horse after it has already left the barn.

An expanding literature points to a significant relationship between adverse childhood experiences and the emergence of mental illness and serious physical illness that can lead to premature mortality in later life. The

Adverse Childhood Experiences (ACE) Study is receiving increasing attention in the mental health community because it shows a clear and consistent correlation between childhood exposure to adversity and trauma and extremely poor physical and behavioral health outcomes. This research was developed through collaboration between the Centers for Disease Control (CDC) and the Kaiser Permanente insurance company. The primary investigators, Robert F. Anda, MD, MS, with the CDC and Vincent J. Felitti, MD, with Kaiser Permanente, showed a graded relationship between adverse experiences (trauma, neglect, parental substance abuse) in childhood and children's risk for increased rates of mental illness, substance abuse and/or life-threatening physical illness. Greater than 50 percent of respondents reported at least one adverse experience in childhood. Individuals who reported four or more experiences had a 4 to 12 times higher risk for developing a life-threatening health condition than individuals who reported only one. Additionally, consider that nearly one in eight individuals (12 percent) has had three or more adverse experiences during childhood. Given the associated behavioral difficulties in childhood, and the negative health outcomes later in adulthood, this has profound implications when considering the needs of children and their development.

We know that trauma can cause toxic stress in children. This can lead to many problems in functioning including behavioral challenges, learning difficulties and emotional

dysregulation among others. Toxic stress causes neurochemical changes in the developing brain that, unchecked, can have lifetime implications. While the ACE focused on several health outcomes in the adult stages of life, the lesson is that these psychological injuries occurred in childhood and the problems began to manifest there.

Recently in Philadelphia, a multidisciplinary group of concerned professionals were brought together to discuss the impact of traumatic stress in children, the use of the ACE information, the issue of trauma and toxic stress as a public health crisis and the potential for trauma-informed, integrated systems of care for children and adolescents. The Children's Crisis Treatment Center (CCTC) hosted this well-attended panel discussion and has taken steps to ensure that the dialogue continues. Julie Campbell, CCTC's Coordinator of Trauma-Focused Projects, provided the deeply meaningful narrative of Michael, a child with a history of trauma whose behavioral needs were described through the lens of our current system and then through the lens of an integrated, trauma-informed system of care. While Michael's story was fictionalized, the contrasting paths that he and his caregivers experienced yielded staggeringly different outcomes. Predictably, when Michael and his family were served in a collaborative and integrated system of care, he was able to cope with his past traumas and lead a more happy and productive life. This type of anecdotal narrative

provides a dramatic example of the difference between our current, fragmented system and a trauma-informed, integrated system of care.

Recommendations

While systematic change at this scale is difficult, there are strategies that can move us toward a trauma-informed, integrated system of care and have a great impact on the lives of children and families. The following represent elements that are part of such a system. These are each integral “spokes” on the integration wheel and would require professionals to be proactive and to change their current practices.

Education

A primary activity in creating cooperation and coordination among the various stakeholders in a child’s community involves education. The mental health and primary care providers hold equal responsibility in sharing and bringing information to the wider audience (parents, caregivers, educators, community leaders, camps, recreation leaders). Education around critical topics such as trauma, traumatic stress and their impact on developmental, behavioral and physical health outcomes must be delivered and understood by stakeholders. This can be done through the use of fact sheets, town hall meetings, home and school assemblies and many other formats. The goal is not only to educate but also to

decrease stigma around mental health and begin a dialogue within the community.

Collaborative Referral and Consultation

Another key element to the success of integration lies in the system's ability to seamlessly and effectively communicate and share information. While the current health care system utilizes referrals rigorously to direct patient care, it provides very poor coordination and has rarely included bidirectional feedback from one service to another. The increased use of electronic health records and health passports can assist in integration, but a truly coordinated system would also employ the greater use of consultation between providers. An example might include a family presenting with behavior concerns for a child in the primary care office. In a collaborative system, the primary care physician would have the ability to speak directly with a mental health professional about the concerns at the time that the family relates them. When the consultation occurs, all parties would have the ability to discuss needs and strategies. The teams would be able to learn from each other and together provide a unified treatment plan, and families would be better able to follow through with referrals and participate in coordinated, interdisciplinary treatment team meetings. The goal here would be to provide immediate, bidirectional dialogue that facilitates an understanding of the family and their

treatment preferences and to support them in overcoming treatment barriers through collaboration.

Screening and Prevention

“Mass screening in primary care could help clinicians identify missed cases and increase the proportion of depressed children and adolescents who initiate appropriate treatment. It could also help clinicians to identify cases earlier in the course of disease." -U.S. Preventative Services Task Force

An extremely promising tool that developed out of the ACE research was the Adverse Childhood Experience Questionnaire. This brief screening tool addresses an individual’s exposure to specific life stressors and/or trauma and essentially records the various types of trauma exposures. This simple score is correlated to the risk for future mental or physical illnesses later in life, and it can also be utilized to assess the need for intervention. The ACE Questionnaire has potential as a screening tool in the primary care setting as a means to prevent future mental and physical illness in children and adolescents. Medical and mental health professionals who use the tool have the opportunity to understand these risk factors and coordinate services prior to the emergence of serious behavioral or physical health issues.

Toward Integration

There are several models available that address an integrated system. Some of the differences discuss having a central point of access for services. There are multiple points of access when considering children's services. Given children's special needs, it makes the most sense at this time to center the model in the primary care office and the school. The elements of integration described above reflect the best case scenario for an integrated model that serves children and adolescents. When brought together, they create a system that is responsive and preventative. These elements foster education and central access and greater continuity and collaboration, and they place a high value on the interconnected relationships between providers, families and the community. The resulting system yields the benefits of shared expertise that ultimately serves the goal of prevention rather than intervention.

Conclusion

Our system as it exists currently tends to focus on, and treat, the "what". In other words, we consider what the child is experiencing and attempt to fashion our interventions to remedy the immediate problem. While symptom reduction and elimination are legitimate goals, there is a risk of ignoring the "why". In other words, why is this happening? If we are not working together to address the why, then we will never achieve meaningful, lasting change. For example, in the case of a diabetic patient, we

would not simply treat the disease with medication; we would work with the patient to alter his or her diet. In a truly integrated system, we would also look at the person's whole community, such as access to fresh and healthy foods, types of stressors experienced in his or her neighborhood, what types of family supports are available to assist in the patient's care and monitoring, etc. While the primary care doctor may need to prescribe medication, it is also critical to look to behavioral causes and factors. This can only be achieved through multidisciplinary collaboration and an integrated dialogue.

The road to meaningful integration is lined with challenges and opportunities. It would be easy, even understandable, for the health care communities to resist integration based on how difficult systematic change is. However, when we consider the benefits to children and families, and to our overall society, these objections must fall away. The effects of toxic stress and trauma on children are debilitating across the lifespan. The ACE research mentioned here points to that definitively. If this stress and trauma are left unchecked, or in the current fragmented system of care, we will continue down a path of multi-generational re-traumatization that leads to overwhelmingly poor health outcomes. Given the research, the availability of information supporting the mind-body connection and the unique opportunity presented through the Affordable Care Act, it is critical that we continue toward a meaningfully integrated system

of care. The well-being of children, their families and our communities, as well as the overall success of health care in this country, hangs in the balance.

Children's Crisis Treatment Center is a private nonprofit agency that specializes in providing mental/behavioral health services to children and their families. CCTC staff members are dedicated to addressing the impact of childhood abuse, neglect, traumatic events and other challenges that can affect child development. For over 40 years, CCTC has developed and implemented innovative ways of helping children as young as 18 months old and their families cope with obstacles that interfere with their emotional, social and cognitive growth. Services and programs are provided at the Center as well as in the home, community and schools.

References

California Institute for Mental Health. (2011). Integration of mental health, substance abuse, and primary care services: Embracing our values from a client and family member perspective. Sacramento, CA. http://www.integration.samhsa.gov/sliders/slider_10.3.pdf

Centers for Disease Control (CDC). (2013). Essentials for childhood: Steps to create safe, stable and nurturing relationships. Atlanta, GA. Retrieved from http://www.cdc.gov/violenceprevention/pdf/efc-01-03-2013-a.pdf

CDC. (2013). Prevalence of individual adverse childhood experiences. Atlanta, GA. Retrieved from http://www.cdc.gov/ace/prevalence.htm

Hogg Foundation for Mental Health. (2008). Connecting body and mind: A resource guide to integrating health care in Texas and the United States. Austin, TX: M. Lopez, B. Coleman-Beattie, L. Jahnke, & K. Sanchez. Retrieved from http://www.hogg.utexas.edu/uploads/documents/IHC_Resource_Guide1.pdf

National Alliance on Mental Illness. (2011). A family guide: Integrating mental health and pediatric primary care. Arlington, VA: D. Gruttadaro & D. Markey. Retrieved from http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf

The National Child Traumatic Stress Network (NCTSN). (2011). Facts for policy makers: The need for an integrated system of care for youth with traumatic stress & substance use disorders. Los Angeles, CA & Durham, NC: H. Merbaum (Capital Decisions, Inc.) & E. Gerrity (National Center for Child Traumatic Stress, Duke University). Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/policybrief1_traumatic_stress_and_substance_use.pdf

NCTSN. (2008). Integrated care within the patient centered medical home: The health center perspective.

Los Angeles, CA & Durham, NC. Retrieved from http://www.nctsn.org/content/integrated-care-within-patient-centered-medical-home-health-center-perspective

U. S. Preventive Services Task Force. (2009). Screening for child and adolescent depression in primary care settings. Rockville, MD: S. B. Williams, E. A. O'Connor, M. Eder, & E. P. Whitlock. Retrieved from http://www.uspreventiveservicestaskforce.org/uspstf09/depression/chdeprart.htm